# Integration of Blueprint and DVHA VCCI

### **DVHA VCCI**

### **DVHA/VCCI** Activities

- Outreach eligible/referred members and access clinical, behavioral and psycho-social need
- 2. Facilitate access to PCP/ Medical Home and/or behavioral health service
- 3. Develop a goal based POC working with member, PCP and other service providers to improve health status
- 4. Facilitate evidence based care management (gap analysis, medication adherence, coaching/health literacy support, etc...) using individual and population based tools
- 5. Facilitate socio-economic resources (food, shelter, etc.) and engagement with local partners for sustainability
- 6. Home, provider or other in-person and phone assessments, coaching and behavioral change support, using MI to foster progression in goal achievement
- 7. Continuous evaluation and strength based coaching to build skill and confidence in self-management
- 8. Assure communication and care coordination among primary and specialty care providers
- 9. Facilitate transition between levels of service (IP to OP: VCCI to CHT)

#### Eligibility Criteria for Referring to VCCI

- 1. Ages: individuals up to age 64, (assume SSI at 65),
- 2. Medicaid primary coverage (no dual insured); Population Stratification targeting high risk, high cost, medically complex cohort (multiple comorbidities, providers, poly pharmacy, high IP/ED usage for ACSC)
- 3. Intensive case management required (complex medical and psychosocial need) and not receiving other CMS case management services
- 4. Limited health literacy with respect to medical condition(s)
- 5. Medical, behavioral and/or psychosocial instability adversely impacting health and generating high utilization patterns
- 6. Emerging needs identified that could destabilize future plans for health improvement (housing instability, pharmacy non-adherence)
- 7. Substance use/abuse history including medication assisted therapy (MAT) and post induction phase with stabilized SA tx (hub/spoke)
- 8. PCP, hospital or AHS referral for high risk factors impacting health
- 9. High Risk Pregnant women including MAT (pilot Franklin County)

#### **Shared Tools**

- 1. Evidence-based guidelines
- 2. Patient Care Plans
  - Action Plans
  - Clinical Data
  - Patient Health Briefs
- DocSite Clinical Tracking Tool
- 4. Population reports (NCQA): gaps in care

#### Transitioning from DVHA VCCI to Blueprint CHT

- 1. General and at least one disease specific assessments performed
- 2. Care plan implemented and mutually agreed upon by beneficiary and provider (readiness for change)
- 3. Initial coaching to evidence-based guidelines performed; action plan(s) initiated
- 4. Basic knowledge about condition(s) and motivated to change
- 5. Care plan goals and objectives related to the primary diagnosis met or partially met/in process
- 6. Medical home established and utilizing
- 7. Medical, behavioral and psychosocial stability stabilized

## **Blueprint CHT**

#### **CHT Activities**

- 1. Provides ongoing support for general patient population in Patient Centered Medical Homes (PCMHs) across a community
- 2. Work closely with PCPs to optimize adherence rates with age and gender appropriate health maintenance and prevention
- 3. Work closely with PCPs to optimize ongoing adherence with individual care plans
- 4. Work closely with PCPs to monitor and evaluate care plans with modifications as needed
- 5. Work closely with PCPs to support achievement of self-management goals with reevaluation and modification of self management goals and plans as necessary
- 6. Linkages to social support and economic services that contribute to health and well being
- 7. Work closely with PCPs to coordinate care across all domains of the healthcare system
- 8. Work closely with PCPs to assure that care support is suited by USPSTF recommendations and disease specific guidelines adapted by the Blueprint providers
- Continuous evaluation of the need to transfer care back to DVHA and/or case closure